

**WEST COVINA (909)622-8047 PH (626)337-4425**  
**SAN GABRIEL VALLEY PERINATAL MEDICAL GROUP, INC.**  
**APPOINTMENT INTAKE INFORMATION SHEET**

Today's Date \_\_\_\_\_ **PRENATAL SCREENING FORM #** \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_ Cell Number (\_\_\_\_\_) \_\_\_\_\_

DOB: \_\_\_\_\_ Age \_\_\_\_\_ Language: \_\_\_\_\_ Social Security # \_\_\_\_\_

Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Referring M.D. \_\_\_\_\_ **Signature of M.D.** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ Contact \_\_\_\_\_

Gravida: \_\_\_\_\_ Para: \_\_\_\_\_ LMP: \_\_\_\_\_ EDC: \_\_\_\_\_ (U/S Done on: \_\_\_\_\_; GA @ U/S: \_\_\_\_\_)

**Please fax a copy of patient's insurance card, signed patient information sheet, prenatal records, ultrasounds, AFP results (front and back), pertinent laboratory results and all supporting documentation for your diagnosis. Thank You.**

**Clinical indications for services requested:**

1. \_\_\_\_\_ **ICD.10** \_\_\_\_\_
2. \_\_\_\_\_ **ICD.10** \_\_\_\_\_
3. \_\_\_\_\_ **ICD.10** \_\_\_\_\_

**PLEASE CHECK ALL THAT APPLY**

- Ultrasound with Consultation & Doppler, if applicable – 76811, 99204, 76817, 76820, 76827, 93325**
- This is a high risk pregnancy and I request Co-management of pregnancy**
- NT/AMA –NT with 1<sup>st</sup> Trimester ultrasound/Genetic Counseling (11 2/7 – 14 wks) – 76813, 76801 & 96040x3 and/or S0265x5**
- NT with 1<sup>st</sup> Trimester ultrasound (11 2/7 – 14 wks) - 76813 & 76801**
- Fetal Echocardiogram – 76825, 76827, 93325**
- Genetic Counseling – 96040 INSURANCE or S0265 Medi-Cal HMO**
- Abnormal AFP/FTS: Includes Genetic counseling/Ultrasound/CVS or Amniocentesis**
- Patient Declines Genetic Counseling**
- Fetal Non-Stress Test (NST) please select**
  - One time only - 59025, 76815**
  - 1 time per week - 59025x16, 76815 x 8**
  - 2 times weekly until delivery - 59025 x16, 76815 x8**
- Vaginal Ultrasound Cervical Length - 76817**
  - One time only**
  - Every 2 weeks until 24 weeks**
- Doppler Study – frequency as determined by perinatologist (please select)**
  - Umbilical Artery - 76820**
  - MCA – Middle Cerebral Artery - 76821**
- AMA/FAMILY HX/ABNORMAL ULTRASOUND – Includes: Genetic Counseling/Ultrasound/CVS or Amniocentesis – 99204, 96040x3, S0265x5, 76811, 59015, 76945 OR 59000, 76946**

APPOINTMENT: \_\_\_\_\_ TIME: \_\_\_\_\_ CPT CODES: \_\_\_\_\_